

**STATE OF MAINE**  
**BOARD OF PHARMACY**

**APPLICATION  
FOR  
REGISTRATION**

**Pharmacy Technician  
Pharmacy Technician Advanced  
Pharmacy Technician Student Intern**



Department of Professional and Financial Regulation

Office of Licensing and Registration  
35 State House Station  
Augusta, ME 04333-0035

Office Telephone: (207) 624-8689 or (207) 624-8600  
TTY/HEARING IMPAIRED (207) 624-8563  
FAX: (207) 624-8637

Office located at: 122 Northern Avenue, Gardiner, Maine  
Email: [jennifer.mooney@maine.gov](mailto:jennifer.mooney@maine.gov)

<b>APPLICATION INSTRUCTION PHARMACY TECHNICIAN</b>
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**THE FOLLOWING IS INCLUDED IN THIS PACKET**

- ☐ Application for registration
- ☐ Credit card authorization form, if paying by credit card, please submit the enclosed authorization form with your application.

**THE FOLLOWING IS THE APPLICATION PROCEDURE:**

- Complete the application for registration and submit to the Maine Board along with the required fee of **\$40.00**. This fee is for the \$25 registration and the \$15.00 fee for the Criminal History Record Check, payment may be made in the form of a check or money order payable to Treasurer, State of Maine, or by credit card, VISA, or MasterCard – (see credit card authorization form).

Pursuant to 5 M.R.S.A. §5301-5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration **requires** a criminal history records check as part of the application process for each application filed with this office.

Public Law Chapter 401, sec. W-1, amends Title 25 §1541, sub-§6 to allow the State Bureau of Identification to charge a fee to government organizations for services provided. As of October 1, 1999 all criminal background checks of individuals are subject to a fee as determined by the Commissioner of Public Safety, which shall be \$15.00 as of May 1, 2003.

NOTE: This is an abbreviated checklist and does not replace the requirements outlined in the Pharmacy Laws and Rules. You must review them carefully for more detailed and clarifying information.

Please be advised that once your completed renewal application form is received, it will take approximately 14 working days for processing. Please plan accordingly.

The Board of Pharmacy requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted or if your application is incomplete.** Documents that have been modified or altered in any way will not be accepted.



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DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
BOARD OF PHARMACY  
35 STATE HOUSE STATION  
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04333-0035

Office use only

Cash # \_\_\_\_\_

License#: \_\_\_\_\_

4380 1425 \$25.00

4308 2619 \$15.00

JOHN ELIAS BALDACCI  
GOVERNOR

ANNE L. HEAD  
DIRECTOR

APPLICATION FOR PHARMACY TECHNICIAN REGISTRATION

Registration Fee: \$25.00  
Criminal History Record Check Fee: \$15.00  
TOTAL FEE DUE: \$40.00

Please Make Check Payable to Treasurer, State of Maine  
or complete credit card authorization form

Type of registration (Please check one box):

- ☐ Pharmacy Technician  
☐ Pharmacy Technician Advanced

- Pharmacy Technician  
☐ Pharmacy Student  
☐ Student Intern  
☐ Pharmacy Graduate

**(Section 1)** This section to be completed by all applicants

Name of applicant: \_\_\_\_\_  
(Print legibly)

Any other names used: \_\_\_\_\_  
(Print legibly)

Contact address: \_\_\_\_\_  
Street or P.O. Box

City/Town State Zip Code County

Contact Tel: \_\_\_\_\_ Email address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

You must respond to the following questions:

Have you ever been convicted of a crime other than a minor traffic violation? ☐ YES ☐ NO  
If yes, please describe below, in detail, the crime(s), list date(s), and submit a copy of the court judgments(s) as well as a letter from you explaining the circumstances surrounding your conviction.

Has any state or territory of the U.S. or province/territory of Canada EVER denied your application for any type of professional license, certificate or registration, or taken any disciplinary action against the license issued to you in that jurisdiction (including, but not limited to, warning, reprimand, fine, suspension, revocation or restrictions in permitted practice, probation with or without monitoring)?

☐ YES ☐ NO

If yes, please describe below, in detail, the circumstances of the action(s) taken and submit a copy of the consent agreement or board order.

**(Section 2)** This section to be completed only if you applying for a ***pharmacy technician advanced registration***, pursuant to Chapters 1 and 7 of the Board's rules:

I, \_\_\_\_\_, hold the designation of Certified Pharmacy Technician ("CPhT") as issued by the Pharmacy Technician Certification Board ("PTCB") and have maintained the certification in full force and effect.  
(applicant signature)

Date certification initially issued: \_\_\_\_\_ Certificate No. \_\_\_\_\_ Expiration Date: \_\_\_\_\_

(Please attach a copy of your PTCB certification)

**OR**

I, \_\_\_\_\_, have successfully completed the National Community Pharmacy Technician Training Program and passed the corresponding National Pharmacy Technician examination.  
(applicant signature)

Date completing the training program: \_\_\_\_\_

Date passed the corresponding NPT examination: \_\_\_\_\_

(Please attach a copy of your examination results)

**(Section 3)** This section to be completed only if you are apply for a ***pharmacy technician registration as a pharmacy student, student intern or pharmacy graduate***, pursuant to Chapters 6 and 7 of the Board's rules:

College which you are currently enrolled in a pharmaceutical program:

Name of Institution \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Telephone Number \_\_\_\_\_

List the date that you completed your second year of the pharmacy degree program you are enrolled in: \_\_\_\_\_

Name of Preceptor: \_\_\_\_\_ (print legibly)

Preceptor's pharmacy license number \_\_\_\_\_ license expiration date: \_\_\_\_\_

(Section 4) This section to be completed by all applicants:

**EMPLOYMENT (please list all pharmacy locations where you are currently employed):**

1. Name of pharmacy: \_\_\_\_\_ License #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Pharmacist in charge: \_\_\_\_\_ License # \_\_\_\_\_  
Signature of Pharmacist in charge: \_\_\_\_\_
2. Name of pharmacy: \_\_\_\_\_ License # \_\_\_\_\_  
Address: \_\_\_\_\_  
Pharmacist in charge: \_\_\_\_\_ License # \_\_\_\_\_  
Signature of Pharmacist in charge: \_\_\_\_\_

**LICENSURE OR REGISTRATION IN OTHER STATES:** List each state in which you hold or have ever held any pharmacy technician license or registration.

_____ (State)	_____ (License/Registration Number)	_____ (Expiration Date)
_____ (State)	_____ (License/Registration Number)	_____ (Expiration Date)
_____ (State)	_____ (License/Registration Number)	_____ (Expiration Date)

Use separate sheet of paper if additional space is needed.

NOTE: All registered technicians shall inform the Board, in writing, within thirty (30) days of any change in name, employment, and/or address.

Application forms and/or supporting documents that have been altered, defaced, or compromised will not be accepted.

**Notice regarding Public Information**

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRSA §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

**Notice regarding Social Security Number Disclosure**

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

By submitting this application I understand that the Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

**Signature of applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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### AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

<b>Name:</b> (applicant fees being paid for)		
<b>Mailing Address:</b> (applicant fees being paid for)		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>County:</b>		<b>Telephone:</b>
<b>Name of cardholder:</b> (if other than applicant)		
<b>Mailing Address:</b> (if other than applicant)		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

☐ Visa ☐ MasterCard \_\_\_\_\_  
Card number

Expiration date: \_\_\_\_/\_\_\_\_/\_\_\_\_ in the amount of: \$\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_